

1
FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02833

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02804

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE	
ST. MARYS MARYLAND		b. COUNTY DISTRICT OF COLUMBIA ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 646 D. ST. N.E.	
3. NAME OF DECEASED (Type or print)		First	Middle
LESLIE		FRANCIS	ABELL
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 27, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY US CIVIL SERVICE	
13. FATHER'S NAME JACKSON B. ABELL		14. MOTHER'S MAIDEN NAME ESTELLE GUY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT MRS. EDNA J. ABELL 646 D. ST. N.E. WASHINGTON, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary Infarction INTERVAL BETWEEN ONSET AND DEATH ceased			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Wm. D. Boyd</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) LEONARDTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/5/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. ALOYSIUS CEM.
24. FUNERAL DIRECTOR P. B. ROBINSON		23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND	
VR ALSM (5) 5M 1/65		25a. REC'D BY REGISTRAR DATE FEB 7 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02834

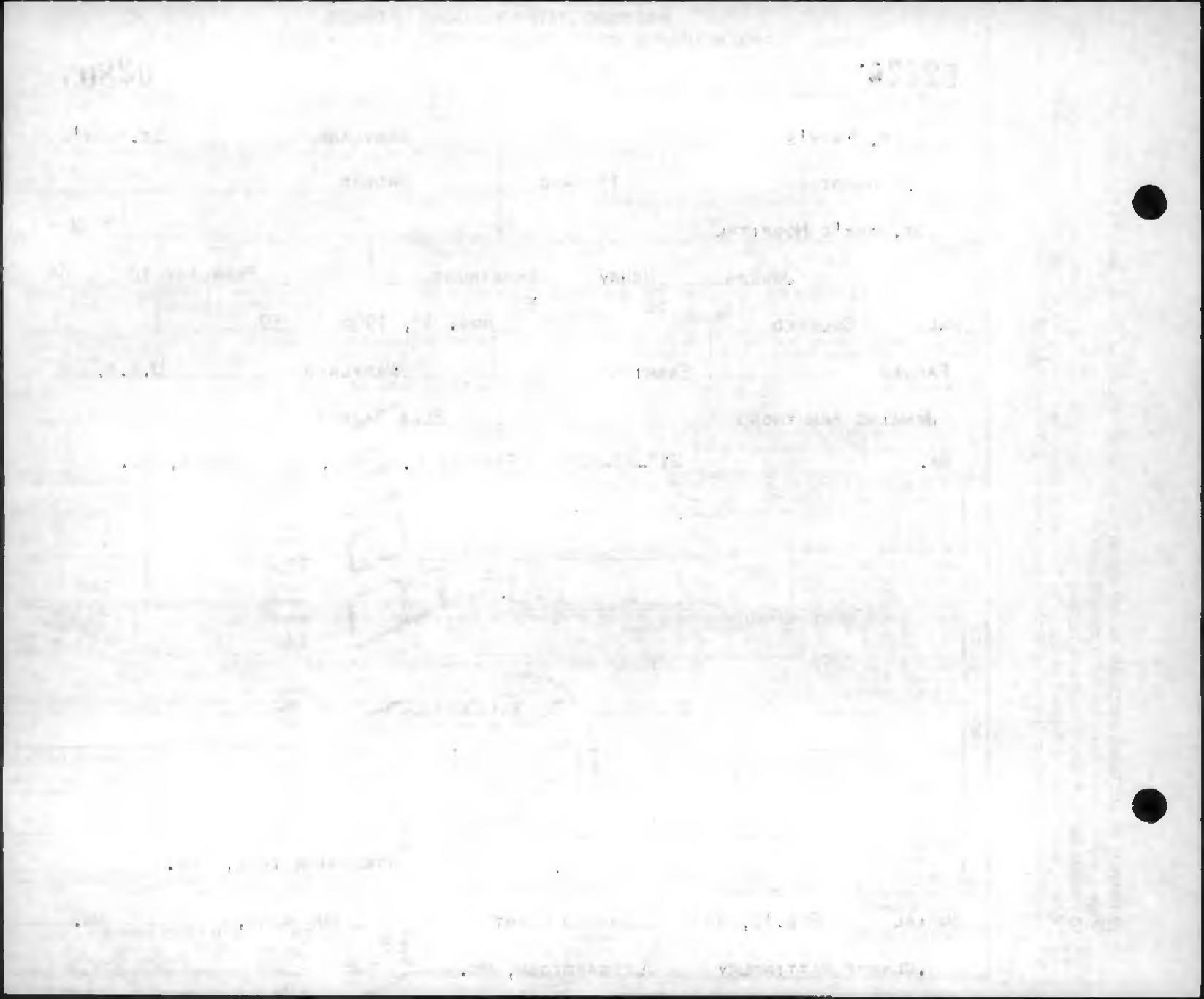
CERTIFICATE OF DEATH

02805

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH HENRY ARMSTRONG		First JOSEPH	Middle HENRY
4. DATE OF DEATH FEBRUARY 13 1966	Month Day Year		
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
8. B. DATE OF BIRTH Aug. 15. 1906		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JENKINS ARMSTRONG		14. MOTHER'S MAIDEN NAME ELLA BARBER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-22-0254	17. INFORMANT FRANCIS G. SWANN, Address MADDOX, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. Cerebrovascular -		INTERVAL BETWEEN ONSET AND DEATH 14d.	
(b) DUE TO Cerebrovascular -		3 mo	
(c) DUE TO Cirr of vertebra		1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1957 to Feb 1966 , that (I) (we) last saw the deceased alive on 12 Feb 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J. Morris		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/14/66
22c. PHYSICIAN'S NAME (Type) MECHANICSVILLE, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SACRED HEART
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, Md.	
25a. RECD BY REGISTRAR FEB 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12835

Item 2 Film G374 3/2/66 mh

CERTIFICATE OF DEATH

028017

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death, may be rendered by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
FOR STATE
HEALTH DEPT.

02836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02806

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3		4		5		6	
FOR STATE HEALTH DEPT.		02836		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		02806		1		2	
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S				3. NAME OF DECEASED (Type or print) DAVID BENNETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK		d. STREET ADDRESS RT. 1 Box 13A26		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. DATE OF DEATH FEBRUARY 15, 1966				f. DATE OF DEATH			
3. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 2, 1911		9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIE BENNETT				14. MOTHER'S MAIDEN NAME ROXANNA JAMES				15. INFORMANT SAVANNAH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. ADDRESS MRS. SAVANNAH BENNETT SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>R. Breitenecker</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-16-66					
EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) PARK HALL, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 19, 1966		23c. NAME OF CEMETERY OR CREMATORIAL HOUSE OF GOD AND PRAYER		23d. LOCATION (City or Town) (County) (State) PARK HALL, MARYLAND					
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS		25a. REC'D BY REGISTRAR FEB 21 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
6M 1/66											

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1967-10-12

00020000

1967-10-12

WATERFALL

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WATERFALL

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02837

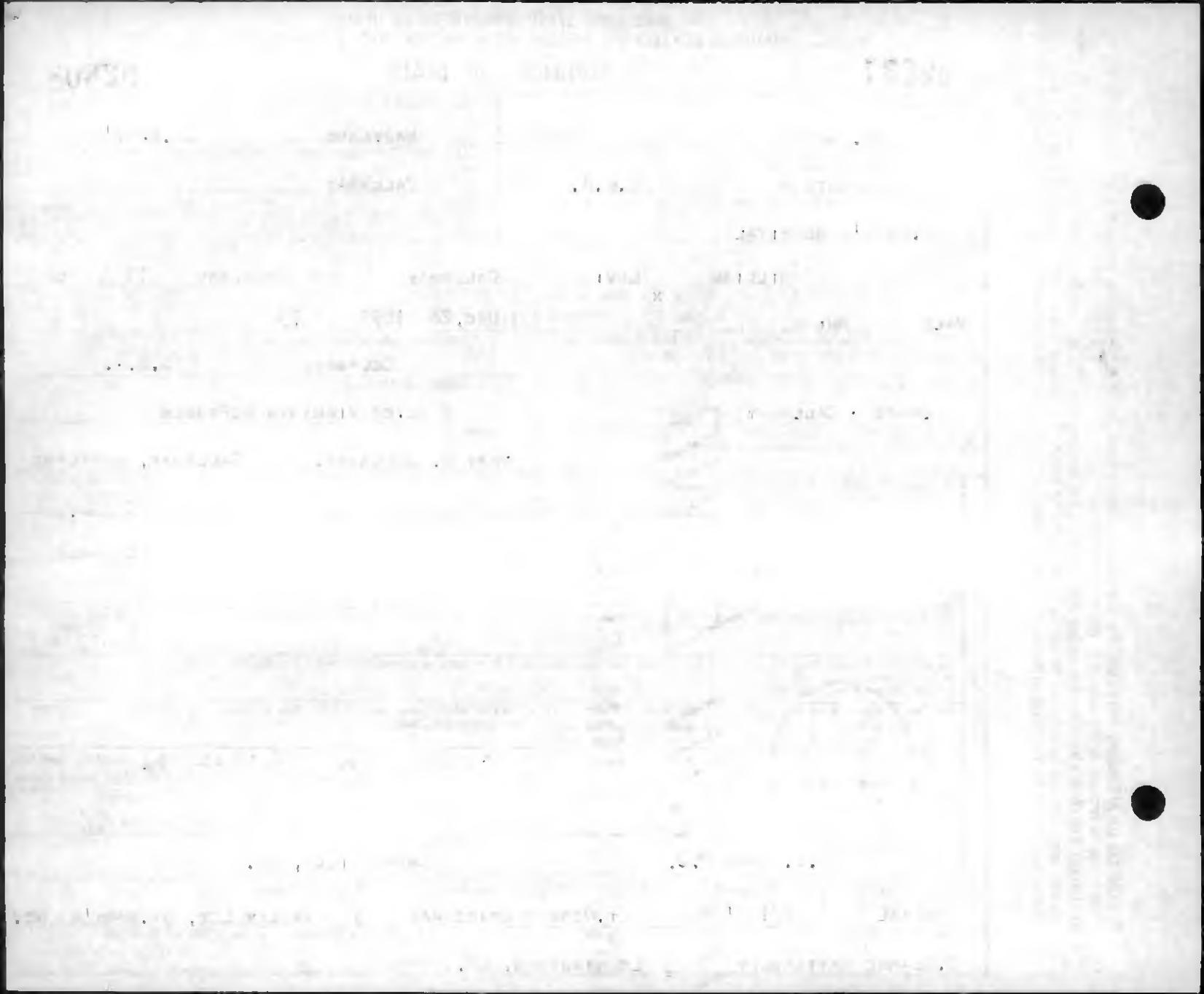
CERTIFICATE OF DEATH

02808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALLAWAY	d. STREET ADDRESS 18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM LEVI CALLAWAY	First WILLIAM	Middle LEVI	Last CALLAWAY	
4. DATE OF DEATH FEBRUARY 13 1966	Month FEBRUARY	Day 13	Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/>	
9. DATE OF BIRTH DEC. 28 1890	10. AGE (In years last birthday) 75 yrs.	11. BIRTHPLACE (County & State, or foreign country) DELAWARE	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H CALLAWAY	14. MOTHER'S MAIDEN NAME ALICE VIRGINIA MCFADDEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MARY O. CALLAWAY.	Address CALLAWAY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 3 days 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1966 to Feb 12 1966 , that (I) (we) last saw the deceased alive on Feb 12 1966 , and that death occurred at 9:30 A.M. from causes and on the date stated above.				
22a. SIGNATURE P.J. BEAN M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Feb 14 1966	
22c. PHYSICIAN'S NAME (Type) P.J. BEAN M.D.		22d. ADDRESS GREAT MILLS, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/15/66	23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE EPISCOPAL	23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, Md.	25a. REC'D BY REGISTRAR DATE FEB 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

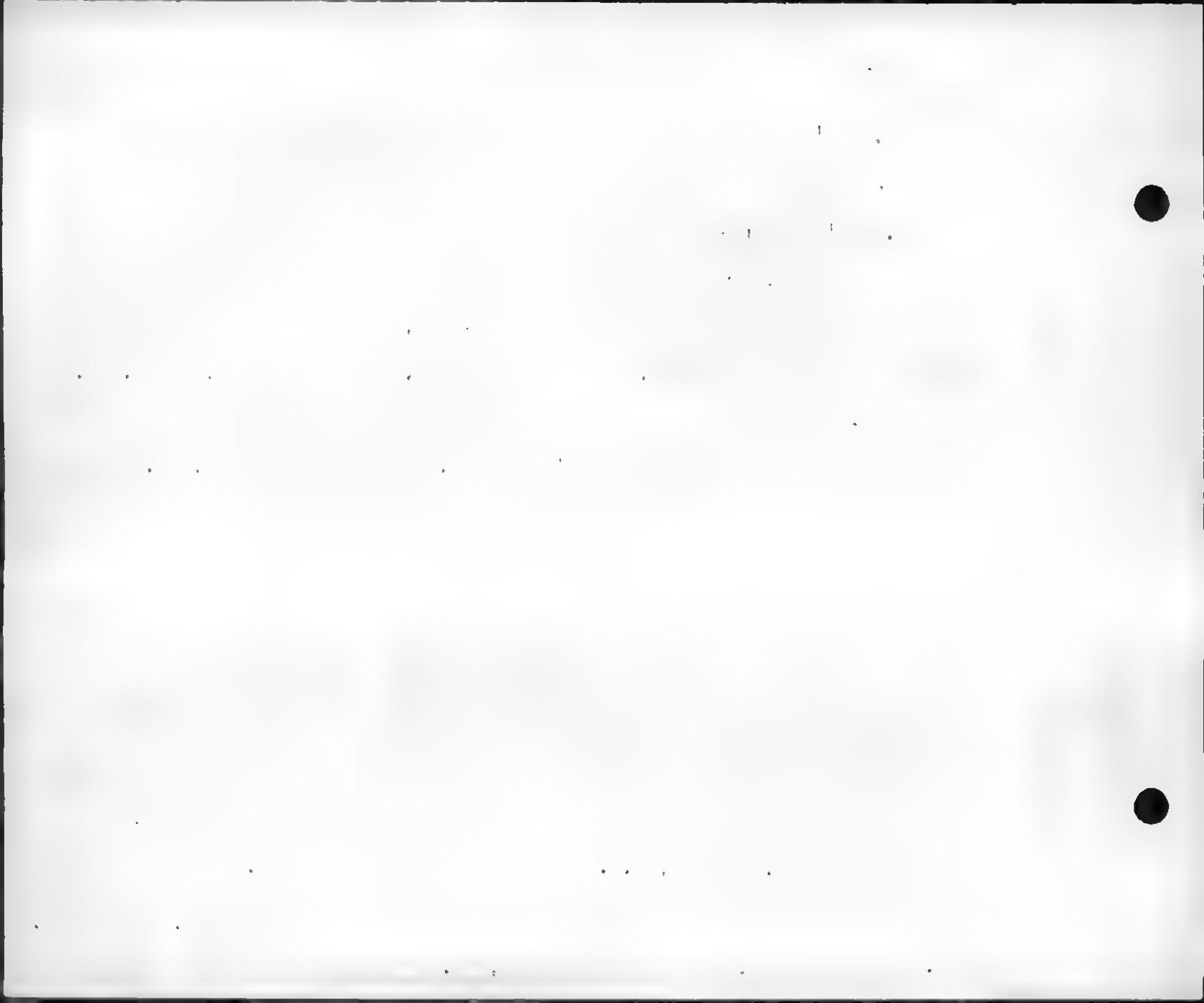
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~keep~~ ^{leave} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~keep~~ ^{leave} ~~within~~ ⁷² hours after death.

02838

CERTIFICATE OF DEATH

02838

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLEY		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM ALBERT COUNTISS		First WILLIAM Middle ALBERT Last COUNTISS		4. DATE OF DEATH FEBRUARY 13 1966		Month FEBRUARY Day 13 Year 1966	
5. SEX MALE COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 17, 1921		9. AGE (In years lost birthday) 44 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State or foreign country) ST. MARY'S MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH J. COUNTISS				14. MOTHER'S MAIDEN NAME MARY ELIZABETH LEE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-34-3381		17. INFORMANT MARY E. THOMAS		Address OAKLEY, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) '65X DUE TO cachexia and cardiac arrest				INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Metastatic carcinoma of lung		(b) DUE TO 6 mo.		(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OAKLEY (County) MD. (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at OAKLEY , MD, from causes and on the date stated above.							
22a. SIGNATURE John F. Fenwick		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-14-66			
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK, M.D.		22d. ADDRESS LEONARDTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/66		23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART		23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR FEB 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge							



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

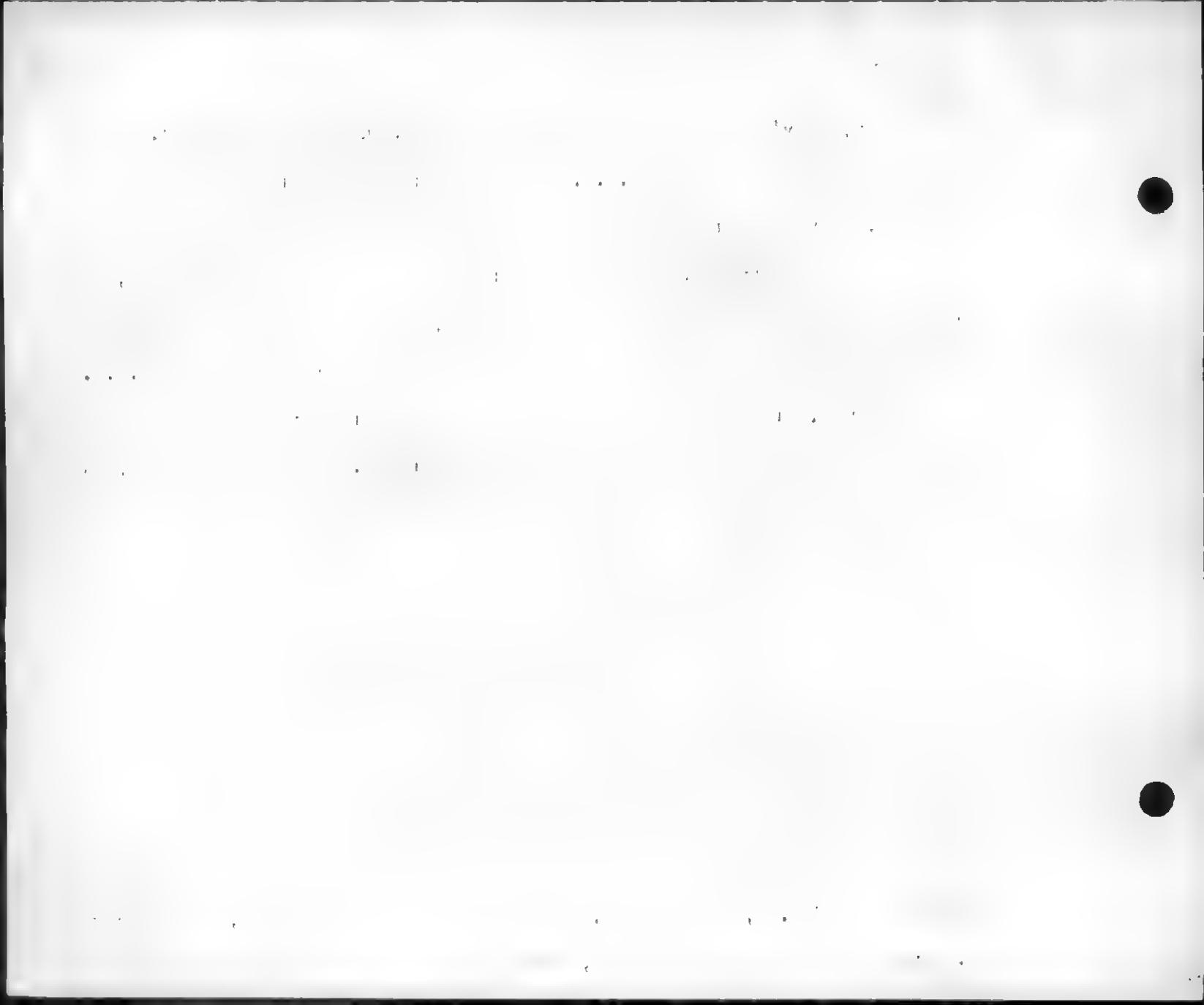
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02833 112810

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN D.O.A.		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS RURAL PINEY POINT	
3. NAME OF DECEASED (Type or print) PAUL KENN LEON DICKENS		First PAUL KENN	Middle LEON
4. DATE OF DEATH FEBRUARY 20, 1966	Month FEBRUARY	Year 1966	Day 20
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED WIDOWED NEVER MARRIED	8. DIVORCED NO
9. AGE (In years last birthday) 55		10. DATE OF BIRTH MAY 5, 1940	11. IF UNDER 1 YEAR Months 25 Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANING		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME IRVING A. DICKENS		14. MOTHER'S MAIDEN NAME CATHERINE BRISCOE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	17. INFORMANT MRS CATHERINE B. DICKENS PINEY POINT, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 9/95 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)		19. INTERVAL BETWEEN ONSET AND DEATH assumed	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 1:35 pm 2-20-1966		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot while in flight	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:35 pm 2-20-1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work at Park Avenue	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Leonardtown
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) Leonardtown	(County) St. Mary's
22. MEDICAL CERTIFICATION ACTUAL SIGNATURE WILLIAM D. BOYD MD		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 2/21/66
EXAMINER'S NAME (Type) WILLIAM D. BOYD MD		22. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ST. MARKS CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. ADDRESS LEONARDTOWN, MARYLAND	25b. LOCATION (City or Town) VALLEY LEE, MARYLAND
25a. REC'D BY REGISTRAR FEB 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

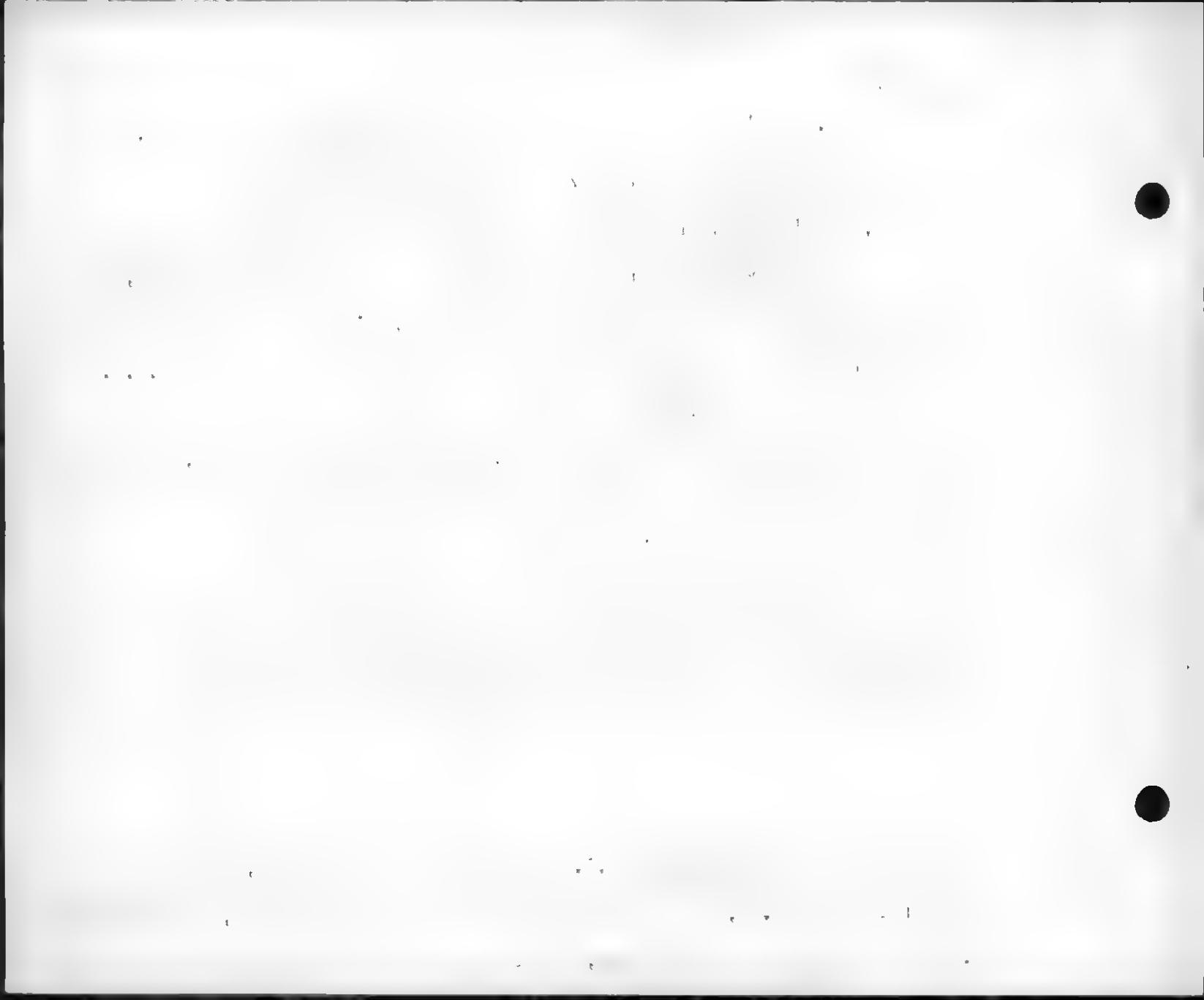


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in the event, within 72 hours after death.

CERTIFICATE OF DEATH						02811		
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 12 DAYS			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL AVENUE d. STREET ADDRESS ST. MARY'S HOSPITAL			02840		
3. NAME OF DECEASED (Type or print) FIRST MARY MIDDLE ELIZABETH LAST DYSON			4. DATE OF DEATH FEBRUARY 10, 1966			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14, 1884	9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months 0 11. IF UNDER 24 HRS Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		
13. FATHER'S NAME JOHN H. DYSON			14. MOTHER'S MAIDEN NAME MARY SHAW			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO NONE	17. INFORMANT CHARLES HENRY DYSON	Address AVENUE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) Arteriosclerotic Heart Disease DUE TO stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 30 min		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHARLES GREENWELL M.D.	20f. (City or town) LEONARDTOWN	(County) MARYLAND
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.								
22a. SIGNATURE <i>John T. Dennis</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 2-14-66	MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIUM SACRED HEART CEMETERY		23d. LOCATION (City or Town) BUSHWOOD , MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR FEB 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15 (4) 20 M 1/68								



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02841

02812

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE	
St. Marys MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1B DOA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Marys Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River	
3. NAME OF DECEASED (Type or print)		First	Middle
FREDERICK (n)		FAISON	
4. DATE OF DEATH		Month	Day
February 11		1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
male negro		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired HM 1		10b. KIND OF BUSINESS OR INDUSTRY	
US Navy		11. BIRTHPLACE (State or foreign country) Youngstown, Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert J. Faison		Frances Stubblefield (dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT	
1948-1961		301 22 0941 US Navy Records - Patuxent River, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH: unmet	
X 254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) auto accident	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:50 p.m. 2-11 1966		20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> RT 235	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Mechanicsville St. Mary Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Wm D. Boyd, M.D.		22. DATE SIGNED 2/11/66	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Transferred & buried 2/12/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Youngstown, Ohio	
24. FUNERAL DIRECTOR J.B. Robinson - Leonardtown, Maryland		23d. LOCATION (City, town or county) (State) Youngstown, Ohio	
25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

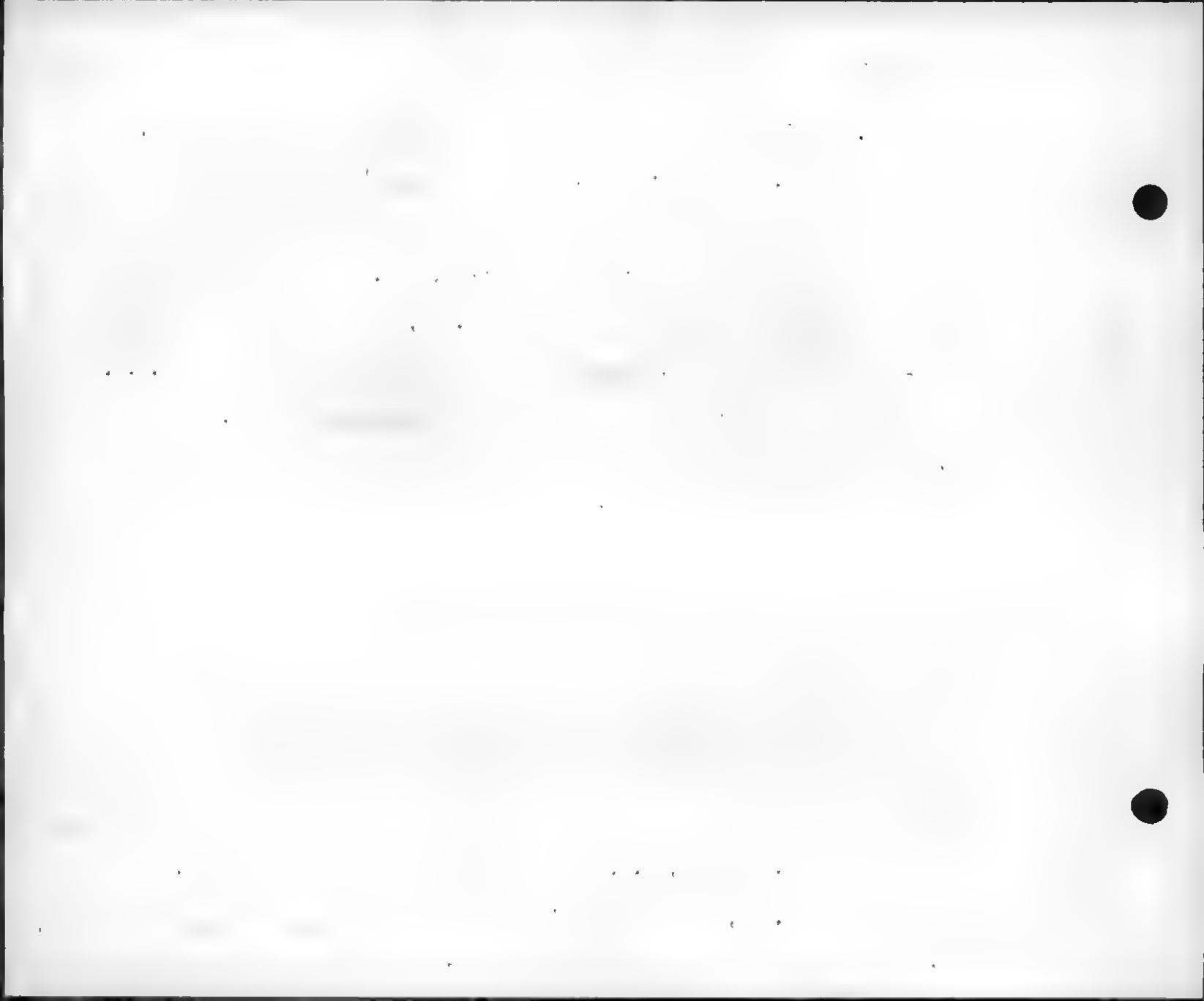
02842

CERTIFICATE OF DEATH

02814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ST. MARY'S				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN, MEDLEY'S NECK LIFE		c LENGTH OF STAY IN b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEDLEY'S NECK				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS				
e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3 NAME OF DECEASED (Type or print) CLARENCE ALFRED GODDARD, SR.		4 DATE OF DEATH FEBRUARY 13 1966	Month Day Year			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
9 AGE (In years last birthday) 76 yrs		10 DATE OF BIRTH Nov. 23, 1889	11 BIRTHPLACE (County & State or foreign country) MARYLAND			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		12 CITIZEN OF WHAT COUNTRY? U.S.A.				
13 FATHER'S NAME WILLIAM SAMUEL GODDARD		14 MOTHER'S MAIDEN NAME IDA ELEANOR REDMOND				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO 17 INFORMANT MARY J GODDARD Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>myocardial infarction and failure</i> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart Disease</i> DUE TO (c) <i>Emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.						
22a. SIGNATURE <i>John F. Fenwick</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>2-14-66</i>			
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK, M.D.		22d. ADDRESS LEONARDTOWN, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL OUR LADY'S CHAPEL MEDLEY'S NECK	23d. LOCATION (City or Town) (County) (State) MEDLEY'S NECK Md.		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, Md.	25a. RECEIVED BY REGISTRAR FEB 17 1966	25b. REGISTRAR'S SIGNATURE <i>Carley Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
M

32243

CERTIFICATE OF DEATH

02816

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL		c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL	
d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)		First JAMES	Middle IGNATIUS	Last GUNN	4. DATE OF DEATH FEBRUARY 22, 1966	Month	Day	Year	
S. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 12, 1898	9. AGE (In years last birthday) 67 yrs	F. UNDER 1 YEAR Months 6	F. UNDER 24 HRS Days 1	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY STATE		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WARREN GUNN			14. MOTHER'S MAIDEN NAME LUCY GANT			Address 310 E MECHANIC ST., PHIL.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 215-18-0378			17. INFORMANT WARREN GUNN			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Diabetes mellitus</i>			<i>25 years</i>
(c)			

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--	--	--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Feb 22, 1966	(County) to	(State) that (I) (we) last

21. I certify that (I) (this hospital) attended the deceased from **Feb 22, 1966** to **Feb 22, 1966** that (I) (we) last saw the deceased alive on **Feb 20, 1966**, and that death occurred at **6A** M. from causes and on the date stated above.

22a. SIGNATURE <i>W.H. Patrick</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-24-66
22c. PHYSICIAN'S NAME (Type) WILLIAM H. PATRICK M.D.		22d. ADDRESS LEXINGTON PARK, MARYLAND	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 26, 1966	23c. NAME OF CEMETERY OR CREMATORIUM ST. PETER CLAVERS	23d. LOCATION (City or Town) RIDGE,	(County) MARYLAND	(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a. ADDRESS LEONARDTOWN, MARYLAND	25b. REC'D. BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital or by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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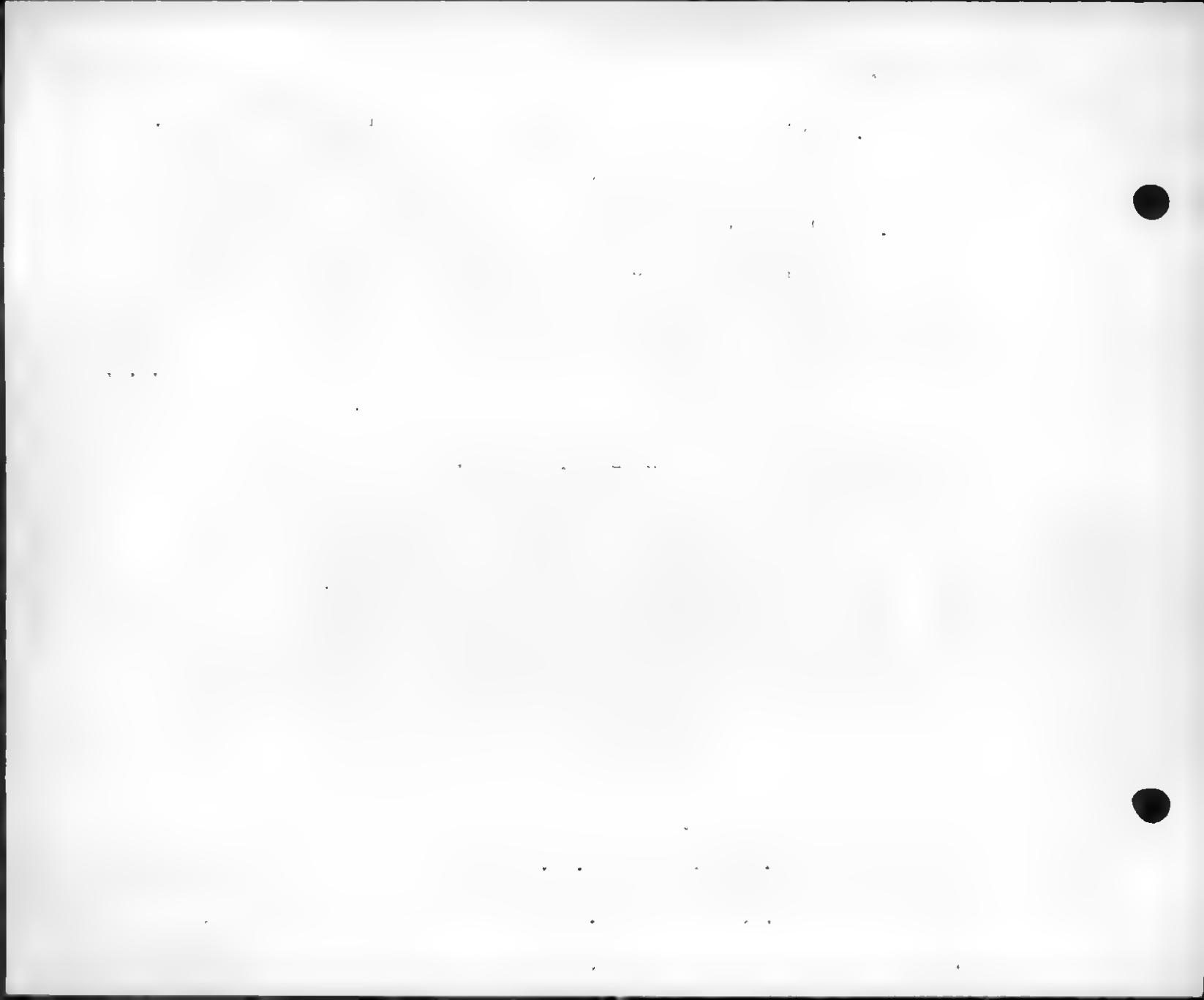
CERTIFICATE OF DEATH

02817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY St. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY St. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. MARY'S HOSPITAL		e. STREET ADDRESS RURAL CALIFORNIA 18-1	
3 NAME OF DECEASED (Type or print) PIERRE CYPRICN LAVOIE		4 DATE OF DEATH FEBRUARY 1, 1966	
S SEX MALE	5 COLOR OR RACE WHITE	6 MARRIED WIDOWED	7. NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH 1881 84 yrs	
10b KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) Months Days Hours Min.	
11 BIRTHPLACE (County & State, or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME ? ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 265-01-8192A 17. INFORMANT OMAR A. LAVOIE Address ANNAPOLIS, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 62 days	
Circulatory Collapse Anemia and anemia Cirrhosis of liver		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral hemorrhage	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19/66 to 11/21/66, that (I) (we) last saw the deceased alive on 11/19/66, and that death occurred at 10:30 P.M. from causes and on the date stated above		22b. DATE SIGNED 2/4/66	
22a. SIGNATURE James P. Jarboe		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS GREAT MILLS, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 4, 1966	23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHNS CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR FEB 10 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

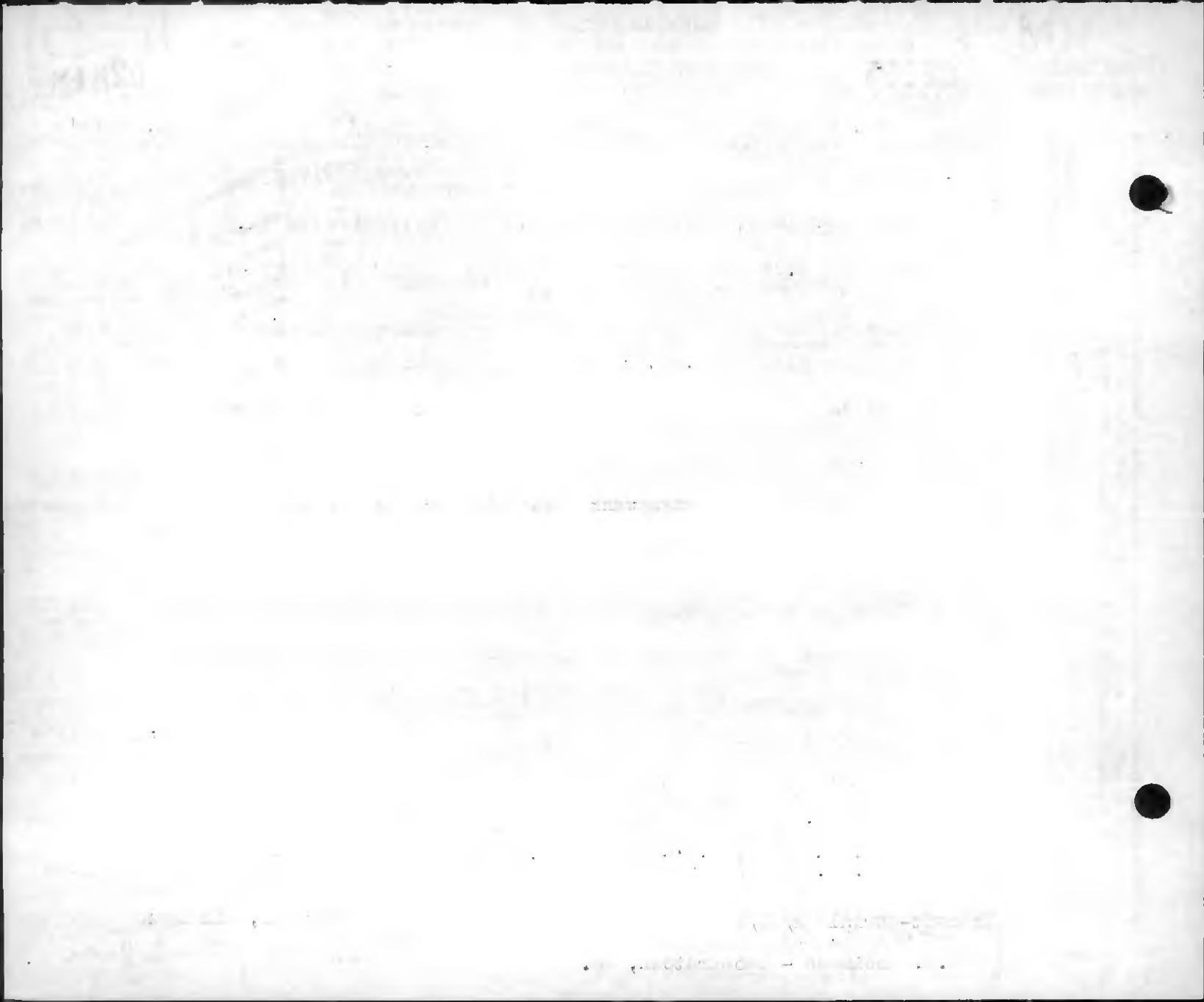


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				3. C. LENGTH OF STAY IN 1b															
St. Mary's MARYLAND				a. STATE Michigan b. COUNTY /Maryland/ 861/MICHIGAN				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River				d. STREET ADDRESS Farwell RR #1															
Station Hospital, NAS, PAXRIV, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				5. NAME OF DECEASED (Type or print) Richard "L" Wilds															
First Middle Last				4. DATE OF DEATH February 21 1966				6. SEX Male Cau 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5-22-47 9. AGE (in years last birthday) 16 1/2 yrs.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman Apprentice				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) Michigan															
13. FATHER'S NAME James Wilds				14. MOTHER'S MAIDEN NAME Patricia Louise Corman				12. CITIZEN OF WHAT COUNTRY? USA															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Aug 65-Feb 66				16. SOCIAL SECURITY NO. 20184719				17. INFORMANT Address Official Navy Records															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9173 Extensive 3rd degree burns INTERVAL BETWEEN ONSET AND DEATH immediate																							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scalding immediate																							
DUE TO DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell into steampit reservoir				20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 2-21 1966				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shop				20f. (City or town) Patuxent River St. (County) Mary's (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>George O. Carr</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) W. D. BOYD, M. D. <i>W. D. Boyd - MD</i>												M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) G. O. CARR, NAS PAX RIV MD												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Transfer to P. B. Robinson				23b. DATE THEREOF 2/23/66				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS				23d. LOCATION (City, town or county) Farwell, Michigan (State)											
24. FUNERAL DIRECTOR P. B. Robinson - Leonardtown, Md.												25a. REC'D BY REGISTRAR FEB 25 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR AISM (5) 5M 1/65																							



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner, Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02846

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02819

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 3 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS RURAL MECHANICSVILLE, 18-1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD SCOTT WOOD		First W	Middle S
4. DATE OF DEATH FEBRUARY 12, 1966	Month FEBRUARY	Day 12	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APRIL 5, 1950	9. AGE (In years last birthday) 15 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANCIS X. WOOD		14. MOTHER'S MAIDEN NAME MARYXXX NELLIE B. BUCKLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT FRANCIS X. WOOD	Address MECHANICSVILLE, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 8254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Auto Thoracic Hemorrhage			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident		
20c. TIME OF INJURY Month, Day, Year Hour 5:40 p.m. 2-12 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) RT 2 35	20f. (City or town) (County) (State) Laurel Grove St Mary Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>WILLIAM D. BOYD</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 2/14/66
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S CEMETERY	23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR DATE FEB 17 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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